

Dealing with substance use disorders in general practice

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Abstract

Substance use disorders are highly prevalent in South Africa. General practitioners are often the first point of contact and play an essential role in correctly identifying the substance use problem. This article provides an overview of the importance of screening for and assessing substance use disorders and identifying the severity of the substance use disorder, so that the right level of management can be ensured. It also examines associated co-morbidities and provides a general overview of the management of substance use disorders.

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Introduction

When considering the management of substance use in general practice, practitioners should focus on legal drugs, such as alcohol and prescription medication, as well as illegal drugs like heroin. The misuse of legal and illegal substances has a detrimental impact on global health.^{1,2} Alcohol use alone is estimated to account for 3.8% of all global deaths and 4.8% of global disability-adjusted life years (defined as the years of life that are lost because of premature death and disability).²

Substance use disorders are highly prevalent among South Africans. Estimates suggest that 13.3% of the population will suffer from a substance use disorder in their lifetime.³ Alcohol is the most commonly abused substance in the country. South Africans are a nation of binge-drinkers. Up to a quarter of current drinkers engage in harmful alcohol use over weekends.⁴ Cannabis is the most common illegal drug that is abused.⁵ The exception is the Western Cape, where methamphetamine abuse is now more customary.⁶ Behavioural addictions, such as pathological gambling, are also of concern, although they will not be discussed here.

As a high percentage of South Africans suffer from a substance use disorder, general practitioners will increasingly play an important role in the assessment and management of patients with these conditions.

Diagnosing a substance use disorder

Substance use occurs on a continuum, ranging from use to abuse to dependence. It is important for practitioners to correctly identify the level of substance use, as this will have

implications for its management. Many people are able to consume substances, such as alcohol, in a responsible manner that does not negatively interfere with their daily functioning. However, people may occasionally misuse substances, for example, driving while under the influence of alcohol. When the misuse of a substance becomes a regular pattern in a person's life, he or she could be diagnosed with a substance use disorder.

Currently, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) distinguishes between substance abuse and dependence.⁷ A diagnosis of substance abuse requires that clinically significant impairment or distress has resulted from a maladaptive pattern of substance use. This may be characterised by any of the following occurring within a 12-month period: the failure to fulfil major obligations at work, school or home (e.g. absence from work); recurrent use of substances in physically hazardous situations (e.g. driving while under the influence); substance-related legal problems; and continued substance use despite recurrent social or interpersonal problems that relate to the use of substances (Criterion A). In addition, the individual should not meet the criteria for substance dependence (Criterion B)⁷. Substance dependence requires that the individual meet any three of the following criteria: tolerance; withdrawal; taking the substance in larger amounts or over a longer period than that intended; a persistent desire or unsuccessful efforts to control the substance use; spending considerable time in activities that relate to obtaining, using or recovering from the substance; giving up social, occupational or recreational activities because of substance use; and continuing with the substance use despite knowing

that use thereof has caused or exacerbated a physical or psychological problem.⁷

The importance of screening and assessment

Despite high levels of substance use disorders, they are often missed in primary care settings. It is critical that screening for substance use forms part of routine assessment. The earlier the substance use problem is detected, the easier it is to manage and to provide effective treatment.

Screening should include questions that relate to the frequency, quantity, method (e.g. smoking or injecting) and type of substances used. Patients may downplay their use. Therefore, it is important to clarify what is meant by “a bit”, “socially” or “just a few drinks”, for example.

There are a number of screening tools that can assist with this process. The CAGE Questionnaire consists of four questions that are used to screen for an alcohol use problem.⁸ These are as follows:

- Have you ever felt you should *cut down* on your drinking?
- Have people *annoyed* you by commenting on your drinking?
- Have you ever felt bad or *guilty* about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to dispel a hangover (an *eye-opener*)?

An affirmative response to two or more of the questions may indicate that the patient has an underlying alcohol use disorder and the practitioner should conduct a more comprehensive assessment of the patient's alcohol use. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire that provides greater accuracy as to the degree of alcohol use,⁹ while the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a useful tool in evaluating the possible misuse of both legal and illegal substances.¹⁰ Both the AUDIT and the ASSIST can be downloaded free of charge from the World Health Organization's website (www.who.int).

Co-morbidity

Patients with substance use disorders often present with co-occurring physical and psychiatric disorders. A myriad of physical complaints may provide an indication of an underlying substance use disorder. These may include gastrointestinal disorders, pancreatitis, liver disorders, hypertension, infectious diseases such as human immunodeficiency virus and Hepatitis B and C (resulting from unsafe sexual practices while under the influence of substances or from drug injection use), and skin infections caused by intravenous administration of substances.¹¹

Co-morbid psychiatric disorders are common in patients with substance use disorders. In particular, such patients may suffer from mood, anxiety,² borderline and antisocial personality disorders.¹³ The risk of suicide attempts is also increased in patients with a dual diagnosis. The general practitioner should ask about ideation, plans or past attempts.¹⁴ Hospital admissions that relate to substance-induced psychotic disorders are also becoming increasingly common in South Africa and often relate to the use of cannabis and methamphetamine.¹⁵ Local data suggest that at least 11.2% of South Africans with a mental disorder will suffer from a co-morbid psychiatric condition (including substance use disorders) in their lifetime.³ The co-morbidity of substance and psychiatric disorders is particularly high in hospitalised psychiatric patients. Fifty-one per cent of patients in a psychiatric hospital in the Western Cape province were diagnosed with a substance use disorder.¹⁵

The interaction between psychiatric and substance use disorders is complex. Substance use may lead to a mental illness, such as a psychotic disorder; substances may be used to “self-medicate” for pre-existing mental health symptoms, for example to regulate mood in bipolar disorder; or both illnesses may occur independently in the same person. Pre-existing mental health symptoms may also worsen with the use of substances. Substance use and mental illness exacerbate each other. Substance use and psychiatric disorders can also mimic or mask the other's symptoms.^{14,16}

It is important that dual diagnoses are identified, so that the patient can be treated for both disorders. Although traditionally it has been suggested that patients should undergo treatment for their substance problem prior to addressing other mental health problems, this is difficult to implement. Patients with co-morbid conditions are likely to struggle to remain abstinent for the required length of time. Therefore, integrated treatment is recommended. The patient should receive interventions for both the substance use and mental disorder in the same setting.^{12,14,16}

Management

Brief interventions can be very effective in halting a person's substance misuse, before it progresses to dependence.¹⁷ Brief interventions can be conducted in as few as five to 15 minutes. Objective, nonjudgemental feedback should be given to the patient on his or her substance use. Referring to the results of screening tools can be helpful. Following feedback, the practitioner should provide clear advice regarding the inherent risks in continued use of the substance. It is also useful to weigh up the advantages and disadvantages of using the substance with the patient so that discrepancies become apparent. The practitioner should provide guidelines on low-risk drinking in patients

who occasionally misuse alcohol, but who do not meet the criteria for a substance use disorder. Low-risk drinking includes no more than two standard drinks a day and at least two alcohol-free days a week.¹⁷ Total abstinence from alcohol and other drugs should be recommended to pregnant women. They should also be made aware of the resultant risks to the foetus when they drink or use drugs. The practitioner should engage with the patient in an empathic manner and provide the necessary support. Confrontational approaches to patients with substance use disorders are counter-productive. The patient is likely to withdraw from further communication with the treatment provider and may not return for treatment.¹⁸

While brief interventions can be highly effective in patients with mild to moderate substance problems, they are not appropriate in patients who have been diagnosed with substance dependence.¹⁷ These patients require referral to specialist services, such as inpatient or intensive outpatient treatment. Where possible, the practitioner should involve family members who can provide social support to the patient and assist with the referral process. The practitioner may assume the role of case manager, exploring possible treatment options with the patient and linking him or her to a network of practitioners and organisations. The application of motivational interviewing may help to persuade patients who do not acknowledge that they have a problem with substance abuse to reach a stage in which they are ready to do so and accept assistance for their disorder. Motivational interviewing is an empathic, nonconfrontational client-centred approach that aims to elicit positive behaviour change by resolving the patient's ambivalence about his or her substance use. It is a technique that can be readily learned by general practitioners. By highlighting discrepancies between a patient's present behaviour and his or her goal, it is hoped that he or she will become motivated to make changes. Rather than being authoritative, motivational interviewing allows the practitioner to evoke the client's own intrinsic motivation for change.¹⁸

Ideally, patients with dependence should be referred for treatment that includes group and individual therapy, skills training, cognitive-behavioural therapy, psychoeducational sessions, family involvement and relapse prevention. Patients who have a history of chronic alcohol dependence may require referral to a hospital or inpatient treatment centre for detoxification. Inpatient management is also recommended for patients who require detoxification from opioids.¹⁹

Patients with opioid dependence, such as heroin, may benefit from opioid substitution therapy, which allows patients to regain functioning in their social life, work and relationships.^{20,21} Because of the potential for abuse, methadone use should always be supervised by another

person. It requires intensive follow-up and repeat urine testing. Therefore, it should only be prescribed if supervision and structure are firmly in place and if a detailed physical and psychological assessment has transpired. As a partial mu-receptor agonist, buprenorphine (Subutex[®]) is a safer option, but should also be supervised initially.²²

Naltrexone (Revia[®]) is an opioid agonist that can be used to treat both alcohol and opioid dependence. It blocks the opioid receptors, lessening the effect of the drug and thereby reducing craving. However, naltrexone is not available in South Africa currently. Acamprosate (Besobrial[®]) is useful during the early period of abstinence from alcohol, as it reduces withdrawal symptoms and craving.^{22,23}

Practitioners should be cautious when prescribing benzodiazepines as, regardless of whether or not they have an underlying substance use disorder, patients on chronic benzodiazepine treatment may find it very difficult to withdraw. Although benzodiazepines may assist with the management of alcohol withdrawal symptoms, they should only be prescribed for short periods (no longer than two weeks) and patients should be informed about their addictive potential.¹⁹

Substance dependence is a chronic disease. It features similar relapse rates to that of other chronic diseases such as hypertension and diabetes.²⁴ Many patients will experience periods of relapse which should be viewed as learning opportunities. Follow-up is critical once patients have completed inpatient or intensive outpatient treatment. Patients may benefit from continued counselling or support groups, such as Alcoholics Anonymous or Narcotics Anonymous.

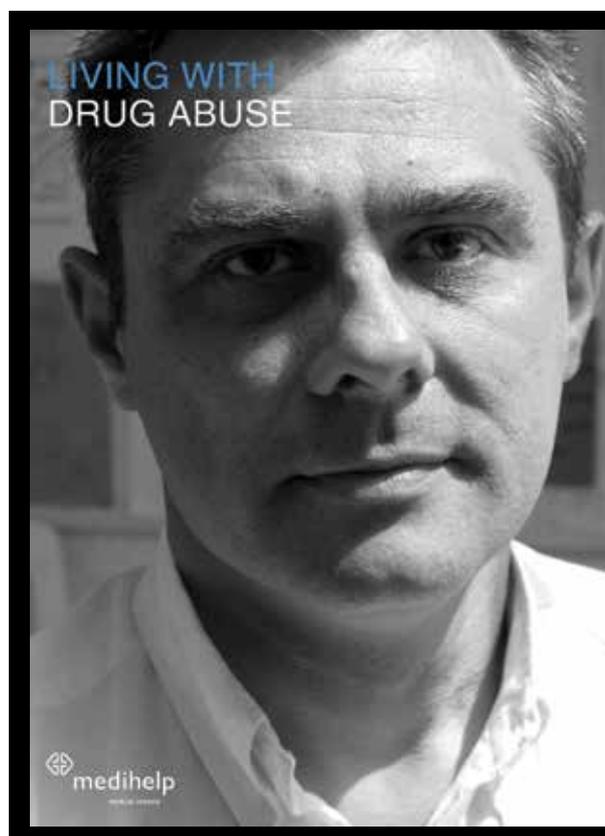
Conclusion

As a result of the high prevalence of substance use disorders, practitioners in general practice will increasingly be expected to screen for, assess and manage patients with substance use disorders. General practitioners may feel that it is not time-efficient to do so, but ultimately, early detection of substance use problems can save the general practitioner time and improve the patient's prognosis.

Practitioners should be aware of the frequent psychiatric and physical co-morbidities that are associated with substance use. Although general practitioners may not feel comfortable treating substance use disorders, simple motivational interviewing techniques can quickly be learned, while co-morbid disorders may respond to standard medical treatment. Building up a strong network of colleagues and referral sources will assist with the comprehensive management of patients with substance use disorders.

References

- Degenhardt L, Hall W. Extent of illicit drug use and dependence and their contribution to the global burden of disease. *Lancet*. 2012;379(9810):55-70.
- Rehm J, Mathers C, Popova S, et al. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet*. 2009;373(9682):2223-2233.
- Herman AA, Stein DJ, Seedat S, et al. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *S Afr Med J*. 2009;99(5 Pt 2):339-344.
- Department of Health, Medical Research Council, OrcMacro. South Africa Demographic and Health Survey 2003. Pretoria: Department of Health; 2007.
- Shisana O, Rehle T, Simbayi LC, et al. South African National HIV prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Cape Town: HSRC Press; 2005.
- Dada S, Plüddemann A, Parry C, et al. SACENDU research brief. Cape Town: South African Community Epidemiology Network on Drug Use (SACENDU); 2012 [homepage on the Internet]. c2012. Available from: www.sahealthinfo.org/admodule.sacendu/SACENSUBriefJune2012.pdf
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington: American Psychiatric Association Press; 2000.
- Ewing JA. Detecting alcoholism: The CAGE Questionnaire. *JAMA*. 1968;252(14):1905-1907.
- Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. AUDIT. The Alcohol Use Disorders Identification Test. Guidelines for use in primary care. 2nd ed. Geneva: World Health Organisation; 2001.
- World Health Organization. ASSIST. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Manual for use in primary care. Geneva: WHO; 2010.
- The Substance Abuse and Mental Health Services Administration. Co-occurring medical and psychiatric conditions: detoxification and substance abuse treatment: a treatment improvement protocol. Rockville: The Substance Abuse and Mental Health Services Administration; 2006.
- Jané-Llopis E, Matytsina I. Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. *Drug Alcohol Rev*. 2006;25(6):515-536.
- Crouse EM, Drake KM, McGovern MP. Personality disorders and drug and alcohol problems. In: A Baker and R Velleman, editors. *Clinical handbook of co-existing mental health and drug and alcohol problems*. New York: Routledge, 2007; p. 309-328.
- Dennison SJ. Substance use disorders in individuals with co-occurring psychiatric disorders. In: Ruiz P, Strain E, editors. *Substance abuse, a comprehensive textbook*. Philadelphia: Lippincott Williams, 2011; p. 721-729.
- Weich L, Pienaar W. Occurrence of comorbid substance use disorders among acute psychiatric inpatients at Stikland Hospital in the Western Cape, South Africa. *African Journal of Psychiatry*. 2009;12:213-217.
- Hitzeroth V, Kramer L. The end of addiction. A comprehensive South African guide. Cape Town: Human and Rousseau, 2010; p. 163-172.
- Babor TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking. A manual for use in primary care. Geneva: World Health Organization; 2001.
- Miller WR, Rollnick S. Motivational interviewing: preparing people for change. New York: Guilford Press; 2002.
- Guidelines for the management of psychoactive substance intoxication and withdrawal in the Western Cape. Western Cape Government; 2012.
- Hubbard RL, Craddock SG, Flynn P, et al. Overview of 1-year outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychol Addict Behav*. 1997;11:279-293.
- Mattick RP, Kimber J, Breen C, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane review. In: *The Cochrane Library, Issue 2, 2003*. Oxford: Update Software.
- Hitzeroth V, Kramer L. The end of addiction. A comprehensive South African guide. Cape Town: Human and Rousseau, 2010; p. 135-148.
- Temmingh H, Myers B. Clinical treatment of substance use disorders in South Africa. In: Ellis GFR, Stein DG, Thomas KGF, Meintjes EM, editors. *Substance use and abuse in South Africa. Insights from brain and behavioural sciences*. Cape Town: UCT Press, 2012; p. 329-366.
- McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness. Implications for treatment, insurance, and outcomes evaluation. *JAMA*. 2000;284(13):1689-1695.



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